U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue Date: 21 April 2004

CASE NO.: 2003-BLA-5071

In the Matter of

DONALD R. WRISTON,
Claimant

v.

PEABODY COAL COMPANY,
Employer

And

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Michael E. Bevers, Esq.,
William D. Turner, Esq.,
For the Claimant[1]

Paul E. Frampton, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a miner's duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on February 22, 1993, respectively. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

[1] Mr. Bevers represented Claimant at the hearing. By notice, dated August 26, 2003, I was informed that Claimant was no longer represented by Mr. Bevers, and would be further represented by Mr. Turner.

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP")) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed his first claim for benefits on May 15, 1980. (Director's Exhibit ("DX") 30). The claim was denied because the evidence failed to establish Mr. Wriston was totally disabled due to pneumoconiosis. The Department of Labor issued the denial on April 10, 1981. The Claimant sought no further appeal of this claim.

The claimant filed his second claim for benefits on August 12, 1986. (DX 31). The claim was denied because the evidence failed to establish that Mr. Wriston had pneumoconiosis and that he was totally disabled due to pneumoconiosis. The Department of Labor issued the denial on October 27, 1986. The Claimant sought no further appeal of this claim.

The present claim was filed on February 22, 1993. The Claimant was denied benefits at the District Director level and appealed this decision. On July 24, 1995, Administrative Law Judge Levin issued a Decision and Order denying Claimant benefits. Judge Levin found that Mr. Wriston is totally disabled due to a respiratory impairment. He also concluded, however, that "the record fails to establish that coal dust exposure is a contributing cause of the impairment which is totally disabling Mr. Wriston." (Levin Decision and Order, July 24, 1995; p. 8). Claimant appealed to the Benefits Review Board. The Board remanded the case to the Administrative Law Judge mandating a determination of material change in condition and separate consideration of each element of entitlement. (BRB Decision and Order, August 22, 1996). Administrative Law Judge Levin remanded the case to the District Director to give the parties an opportunity to develop additional evidence.

On May 16, 2002, the District Director issued a Proposed Decision and Order denying benefits. On June 6, 2002, the claimant requested a hearing before an administrative law judge. On October 28, 2002, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Program (OWCP) for a formal hearing. I was assigned the case on January 22, 2003.

On June 12, 2003, I held a hearing in Beckley, West Virginia, at which the claimant and employer were represented by counsel.[2] No appearance was entered for the Director, Office of

[2] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1-4, Director's exhibits ("DX") 1-75, and Employer's exhibits ("EX") 1, 4, 5, 6 and 7 were admitted into the record.

Employer's exhibit 2 includes X-ray re-readings by Drs. Scott, Wheeler and Scatarige of the December 8, 1993 and October 30, 2002 X-rays. It also includes the curricula vitae of Drs. Scott, Wheeler and Scatarige. Employer's exhibit 3 includes X-ray re-readings by Drs. Scott, Wheeler and Scatarige of the February 2, 1981, September 22, 1986, March 24, 1993 and January 29, 2002 X-rays. These exhibits were not admitted into the record at the hearing. Claimant's Counsel objected to the X-ray readings being admitted based on the over-abundance of X-ray readings submitted by Employer's Counsel. (TR 52). I questioned Employer's Counsel on whether there is any difference in terms of the quality of the readings of Drs. Scott, Wheeler and Scatarige. Mr. Frampton responded: "I don't believe that there is, your honor." (TR 53). Mr. Frampton objected to the limit on admitted X-ray readings.

Mr. Frampton was permitted to decide post-hearing which doctors' readings he wanted submitted. In addition, he was instructed that if he can point out a qualitative difference that distinguishes each one of the three readings, the ruling limiting the amount of readings would be reconsidered. (TR 54). Mr. Frampton did not address this ruling post-hearing, nor did he designate which readings he wanted admitted. Thus, I am admitting the readings of Drs. Scott and Wheeler. The X-ray readings performed by Dr. Scatarige are not admitted into the record. The curricula vitae of Drs. Scott and Wheeler included in Employer's exhibit 2 are also admitted.

Employer submitted the following evidence after the hearing:

i. deposition of Dr. Gregory Fino, dated January 28, 2004;
ii. X-ray readings by Drs. Scott, Wheeler and Scatarige; and
iii. deposition of Dr. George Zaldivar, dated January 26, 2004.

Exhibits (i) and (iii) are hereby admitted into the record and marked as Employer's Exhibits (EX) 8 and 10 respectively. The X-ray readings by Drs. Scott and Wheeler are admitted into the record as Employer's exhibit 9. The reading by Dr. Scatarige is not admitted based on the above-stated ruling.

ISSUES

I. Whether the miner has pneumoconiosis as defined by the Act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled?

IV. Whether the miner's disability is due to pneumoconiosis?

V. Whether there has been a material change in the claimant's condition?

FIDNINGS OF FACT

I. Background

A. Coal Miner

The claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 38 years, as stipulated by the parties. (Hearing Transcript (TR) 8).

B. Date of Filing

The claimant filed his claim for benefits, under the Act, on February 22, 1993. (DX 1). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator[3]

Peabody Coal Company is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart F (Subpart G for claims filed on or after Jan. 19, 2001), Part 725 of the Regulations. (TR 25).

D. Dependents[4]

The claimant has one dependent for purposes of augmentation of benefits under the Act, his wife, Mildred Wriston. (DX 9, TR 22).

E. Personal, Employment and Smoking History[5]

The claimant was born on January 15, 1930. (DX 1). He married Mildred Richmond on December 21, 1957. (DX 9). Ninth grade was the highest grade the Claimant completed in school. (DX 1, TR 22). The Claimant's last position in the coal mines was that of a Ram Car Operator. (TR 24).

He was employed in one or more underground mines for fifteen years or more. The claimant, as part of his duties, was required to load coal into the ram cars, shovel coal if it overflowed and load timbers. Claimant testified that he shoveled coal two to three times a shift. (TR 24). The Claimant retired on January 15, 1992, at the age of 62. (DX 1).

[3] Liability for payment of benefits to eligible miners and their survivors rests with the responsible operator. 20 C.F.R. § 725.493(a)(1) defines responsible operator as the claimant's last coal mine employer with whom he had the most recent cumulative employment of not less than one year.
[4] See 20 C.F.R. §§ 725.204-725.211.
[5] "The BLBA, judicial precedent, and the program regulations do not permit an award based solely upon smoking-induced disability." 65 Fed. Reg. 79948, No. 245 (Dec. 20, 2000).

There is evidence of record that the claimant's respiratory disability is due, in part, to his history of cigarette smoking. Claimant smoked one pack of cigarettes per day from 1946 through 1980. (DX 12; TR 32).

II. Medical Evidence

The following is a summary of the evidence submitted since the final denial of the prior claim.

A. Chest X-rays[6]

There were 34 readings of ten X-rays, taken on January 7, 2004, April 29, 2003, October 30, 2002, January 29, 2002, August 9, 1994, December 8, 1993, September 8, 1993, March 24, 1993, September 22, 1986 and February 2, 1981. (DX 14, 15, 16, 27, 36, 37, 38, 39, 45 and 72; CX 2; EX 1, 2, 3 and 9). Five are positive, by four physicians, Drs. Cohen, Speiden, Bassali and Deardorff, all of whom are either B-readers, Board-certified in radiology, or both.[7] Twenty-eight are negative, by 12 physicians, Drs. Abramowitz, Binns, Cole, Franke, Goginni, Ranavaya, Scott, Shipley, Spitz, Wheeler, Wiot and Zaldivar, all of whom are either B-readers, Board-certified in radiology, or both. Dr. Binns performed a quality only reading of the January 29, 2002 X-ray. A summary of the X-ray evidence as attached as Appendix A.

B. Pulmonary Function Studies[8]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

[6] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[7] *LaBelle Processing Co. v. Swarrow,* 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 f.3d 1273, 1276 n. 2 (7th Cir. 1993)."

[8] § 718.103(a)(Effective for tests conducted after Jan. 19, 2001 (See 718.101(b)), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000). In the case of a deceased miner, where no pulmonary function test are in substantial compliance with paragraphs (a) and (b) and Appendix B, noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the tests demonstrate technically valid results obtained with good cooperation of the miner. 20 C.F.R. § 718.103(c).

Physician **Date** **Exh.#**	**Age** **Hght**	**FEV**$_1$	**MVV**	**FVC**	**Tracings**	**Comprehen-sion** **Cooperation**	**Qualify *** **Conform ****	**Dr.'s** **Impression**
Dr. Cohen 4/29/03 CX 3	73 71 in.	1.85	85	3.59	Yes	Very good Very good	Yes Yes	Severe obstructive defect. There is no clear response to bronchodilators, this does not preclude their clinical use.
Dr. Cohen 4/29/03 CX 3 Post Bron.	73 71 in.	1.99		3.73	Yes	Very good Very good	Yes Yes	
Dr. Zaldivar 10/30/02 EX 1	72 71 in.	2.12		3.64	Yes		No Yes	
Dr. Zaldivar 10/30/02 EX 1 Post Bron.	72 71 in.	2.15		3.87	Yes		No Yes	
Dr. Ranavaya	72 73 in.	1.87		3.16	Yes	Good Good	No Yes	Mixed obstructive/ restrictive

Physician Date Exh.#	Age Hght	FEV$_1$	MVV	FVC	Tracings	Comprehen-sion Cooperation	Qualify * Conform **	Dr.'s Impression
1/29/02 DX 72								pattern indicated by reduction in FEV1/FVC% and FVC.
Dr. Ranavaya 1/29/02 DX 72 After Bronch.	72 73 in.	1.92		3.10	Yes	Good Good	No Yes	
Dr. Crisalli 9/26/00 EX 4	70 71 in	2.10	87	3.41	No	Good Good	No No	Mild expiratory air flow obstruction. No restrictive defect. Moderate air trapping. No diffusion defect.
Dr. Crisalli 9/26/00 EX 4 Post Bron	70 71 in	2.28		3.94	No	Good Good	No No	Significant post-broncho-dilator improvement.
Dr. Crisalli 7/14/98 EX 4	68 71 in	1.94	75	2.91	No	Good Good	Yes No	

Physician **Date** **Exh.#**	**Age** **Hght**	**FEV**$_1$	**MVV**	**FVC**	**Tracings**	**Comprehen-sion** **Cooperation**	**Qualify *** **Conform ****	**Dr.'s** **Impression**
Dr. Crisalli 7/14/98 EX 4 Post Bron	68 71 in	2.31		3.69	No	Good Good	No No	
Dr. Crisalli 5/15/97 EX 4	67 72 in	1.80	90	3.44	No	Good Good	Yes No	Moderate expiratory air flow obstruction. Mild diffusion defect.
Dr. Crisalli 5/15/97 EX 4 Post Bron	67 72 in	2.07		3.47	No	Good Good	No No	Significant response to broncho-dilator.
2/6/97 EX 4	67 72 in	2.10		3.44	Yes		No Yes	Mild Obstruction and Low VC
1/7/97 EX 4	66 72 in	1.56		2.83	Yes	Good Good	No Yes	Severe obstruction and low VC
1/7/97 EX 4	66 72 in	1.73		3.53	Yes	Good Good	Yes Yes	Moderate obstruction and low VC
Dr. Rasmus-sen 3/24/93	63 73 in.	2.35	99	3.77	Yes	Good Good	No Yes	Minimal, irreversible obstructive ventilatory impairment.

Physician Date Exh.#	Age Hght	FEV$_1$	MVV	FVC	Tracings	Comprehen-sion Cooperation	Qualify * Conform **	Dr.'s Impression
DX 10								Maximum breathing capacity is minimally decreased.
Dr. Rasmus-sen 3/24/93 DX 10 After Bronch	63 73 in.	2.48	104	4.14	Yes	Good Good	No Yes	
Dr. Zaldivar 12/8/93 DX 27	63 71 in.	2.12	97	4.04	Yes	Good Good	No Yes	
Dr. Zaldivar 12/8/93 DX 27 After Bronch	63 71 in.	2.25	102	4.28	Yes	Good Good	No Yes	

*A "**qualifying**" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP,* 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Appendix B (Effective Jan. 19, 2001) states "(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness…"

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV_1'S of the three acceptable tracings should not exceed 5 percent of the largest FEV_1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

For a miner of the claimant's height of 72 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 2.04 for a male 73 years of age.[9] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.63 or an MVV equal to or less than 82; or a ratio equal to or less than 55% when the results of the FEV_1 tests are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Height	**Age**	**FEV_1**	**FVC**	**MVV**
71	73	1.98	2.55	79
71	72	1.98	2.55	79
73	72	2.13	2.74	85
71	70	1.99	2.57	80
71	68	2.02	2.60	81
72	67	2.10	2.70	84
72	66	2.12	2.71	85
73	63	2.26	2.88	90
71	63	2.10	2.69	84

[9] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th cir. 1995). I find the miner is 72" here, his average reported height.

C. Arterial Blood Gas Studies[10]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date **Ex. #**	**Physician**	**PCO2**	**PO2**	**Qualify**	**Physician Impression**
4/29/03 CX 3	Dr. Cohen	46.1	62.1	No	Arterial blood gases consistent with metabolic and respiratory acidosis and metabolic alkalosis.
10/30/02 EX 1	Dr. Zaldivar	42	76	No	
3/24/93 DX 13	Dr. Rasmussen	39 43*	68 66*	No	
12/8/93 DX 27	Dr. Zaldivar	41	70	No	

*Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

D. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary

[10] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. §718.204(b)(2) permits the use of such studies to establish "total disability." It provides: In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability:…
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Rasmussen, whose qualifications are not in the record, performed the Department of Labor examination. His report based upon his examination of the claimant, on March 24, 1993, notes 44 years of coal mine employment and a 34-year smoking history. (DX 12). Dr. Rasmussen described the claimant's symptoms as first experiencing shortness of breath with effort about ten years ago and chronic productive cough. He mentions that the claimant wheezes in the evenings, in the mornings, and with exertion.

Based on arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Rasmussen diagnosed Mr. Wriston with coal workers' pneumoconiosis. He determined that Claimant's X-ray changes are consistent with pneumoconiosis. In addition, Dr. Rasmussen stated that ventilatory function studies indicated "minimal to moderate loss of respiratory function." He concluded that "[t]his degree of impairment would render this patient totally disabled for resuming his former coal mine employment with its attendant requirement for heavy and some very heavy manual labor."

He opined that the claimant's pulmonary condition was related to his coal dust exposure and cigarette consumption. The coal mine dust exposure being a major contributing factor to his impaired respiratory function. He further found that Claimant is totally disabled and could not resume his former coal mine employment.

On July 1, 1993, Dr. Rasmussen submitted, to the claims examiner, a supplement to his March 24, 1993 report. (DX 19). The evidence considered by Dr. Rasmussen for the March report included an X-ray reading by Dr. Speiden of 1/1 positive for pneumoconiosis. The same X-ray was subsequently read by Drs. Cole and Francke as negative for pneumoconiosis. Dr. Cole read the film as 0/1. Dr. Francke read the film as completely negative. Dr. Rasmussen's July 1, 1993 letter states:

> The new interpretation of the X-ray by Drs. Cole and Francke in no way alter my opinion concerning the presence of coal workers' pneumoconiosis in this case, nor does it alter my opinion that coal workers' pneumoconiosis is a significant contributing factor to this patient's significant pulmonary impairment.

(DX 19).

On February 28, 1994, Dr. Rasmussen wrote a report again stating his finding of coal workers' pneumoconiosis in spite of the findings by Dr. Zaldivar. (DX 37). Dr. Rasmussen concluded that Dr. Zaldivar was incorrect when he stated that none of Mr. Wriston's pulmonary impairment is a result of his coal mine employment. Dr. Rasmussen considers the X-ray to be an imperfect tool and is capable of excluding the presence of even significant pneumoconiosis. Dr. Rasmussen concedes that "the effects of coal mine dust exposure and cigarette smoking are additive, making it totally impossible to separate the effects of cigarette smoking from that of

coal mine dust." (DX 37, p.3). However, Dr. Rasmussen found that Claimant's totally disabling respiratory insufficiency is, in significant part, cause by his "previous coal mine dust exposure."

Dr. Zaldivar is a B-reader and is Board-certified in pulmonary disease, internal medicine, sleep disorders and critical care medicine. (EX 1). His examination report, dated December 28, 1993, based upon his examination of the claimant, on December 8, 1993, notes 44 years of coal mine employment and a 35-year smoking history. (DX 27). In addition to his examination of the claimant, Dr. Zaldivar reviewed four X-ray readings, Dr. Rasmussen's report, a letter from Dr. Deocampo, and physician notes. Dr. Zaldivar described the claimant's symptoms as wheezing of the lungs for ten years.

Based on arterial blood gases, a pulmonary function study, and chest X-rays, Dr. Zaldivar diagnosed no radiographic evidence of pneumoconiosis. Dr. Zaldivar determined that Mr. Wriston's symptoms are consistent with asthmatic problems, which is even with his family history of asthma. Mr. Wriston uses an inhaler which helps his symptoms and represents treatment of asthma. Dr. Zaldivar concluded that, from a pulmonary standpoint, Mr. Wriston would be unable to perform his last coal mining job, because of the shoveling involved. (DX 27).

He opined that the claimant's pulmonary condition was not related to his coal dust exposure. Dr. Zaldivar concluded that Mr. Wriston has "primarily asthma, but some emphysema is also present, judging by his significant smoking habit, which he had in the past." (DX 27).

Dr. Zaldivar submitted an additional examination report, dated January 14, 2003, based on his examination of the Claimant, on October 30, 2002. (EX 1). In preparing his report, Dr. Zaldivar also reviewed his 1993 report and Mr. Wriston's medical records. The Claimant described his symptoms as shortness of breath, no wheezing in past four months, little cough since quitting work, must sleep with two pillows, can climb one flight of stairs and can only walk about 40 yards before becoming short of breath.

Dr. Zaldivar concluded that Mr. Wriston's diffusing capacity is normal. He stated "[t]he fact that he diffusing capacity is normal in my study in spite of the presence of airway obstruction which is mild to moderate means that an asthmatic problem does exist and is present." (EX 1). Dr. Zaldivar determined that asthma is a predominant problem, but emphysema may also be present. He explained "[t]he normal diffusing capacity means that there has been no damage to the capillary beds of the lungs and therefore no significant lung destruction." He stated that airway obstruction comes from inflammation of the airways, not from destruction of the airways.

Dr. Zaldivar remained consistent with his 1993 conclusion that Mr. Wriston suffers from asthma. He acknowledged "[e]mphysema may well be present; however there has not been sufficient lung destruction to produce any problem with the diffusing capacity and therefore asthma remains the major problem regarding his airway obstruction." (EX 1). Dr. Zaldivar found that Mr. Wriston does not have coal workers' pneumoconiosis or any dust disease of the lungs.

Dr. Zaldivar did change his 1993 conclusion regarding disability:

> From the pulmonary standpoint, Mr. Wriston has the capacity to perform his usual coal mining work. In my previous report I stated that shoveling might be beyond the capacity of Mr. Wriston, but this is incorrect. Mr. Wriston has a ventilatory capacity to perform shoveling or even heavy manual labor if so were required.

(EX 1).

On May 20, 2003, Dr. Zaldivar was deposed by Employer's Counsel. (EX 6; EX 7). His medical practice focuses on evaluations of lung disease in general and occupational lung diseases in particular. Dr. Zaldivar's practice consists of treatment of coal miners as patients and examinations for state and federal agencies. (EX 6; p. 6). In preparation for the deposition, Dr. Zaldivar reviewed X-ray readings by Drs. Scott, Scatarige and Wheeler, which were submitted after the date of Dr. Zaldivar's January 14, 2003 medical report. (EX 6; p. 12). He described the Claimant's job as a ram car operator. As description, Dr. Zaldivar stated "he simply moved the car back and forth between the loader and the belt." He also stated that Claimant's job included shoveling and lifting timber. Dr. Zaldivar considered Claimant's job in the mine as light duty work. (EX 7; pp. 16-17).

Dr. Zaldivar discussed the October 30, 2002 pulmonary function test. He found that Claimant's forced vital capacity was "technically in the normal range." The Claimant had no improvement with bronchodilators. He found some air trapping due to obstruction. Dr. Zaldivar stated that the diffusing capacity was entirely normal. He explained that this displays that Mr. Wriston's capillary beds are intact. He found that the lung substance is able to exchange gases very well. From this conclusion, Dr. Zaldivar reasoned that "the obstruction which he has is not a result, for the most part, of destruction of lung tissue." (EX 6; pp. 13-14). He explained that the consequence of the capillary beds being intact display that the obstruction is a result of the inflammation of the airways. He stated "[t]his rules out emphysema as a major component or for that matter coal workers' pneumoconiosis, because either one can result in destruction of the lung tissue when there is damage to the tissue that is measured by breathing tests." (EX 6; p. 14).

Dr. Zaldivar stated that with asthma the breathing capacity varies. (EX 6; p. 16). He reviewed records from Montgomery General Hospital, dated January 1997. Claimant was admitted because he had an exacerbation of chronic obstructive pulmonary disease with bronchospasm. He explained that Claimant "lost acutely breathing capacity, because acutely he had an inflammation of the airways." Dr. Zaldivar stated that such condition was reversed with time and that is typical of an asthmatic condition. (EX 6; pp. 17-19). Dr. Zaldivar testified that bronchospasm is not a problem that is caused by coal dust exposure.

Dr. Zaldivar explained that he did not find coal workers' pneumoconiosis because Mr. Wriston's impairment is reversible. (EX 6; p. 24). He stated that the coal dust he may have inhaled has not caused any permanent damage to the lungs. Dr. Zaldivar acknowledge that Mr. Wriston does have a chronic obstructive pulmonary disease. He clarified that asthma is chronic obstructive pulmonary disease. He made clear "[t]here is a group of individuals that is always obstructed, always have bronchitis and always need to be treated with bronchodilators and they belong in the asthma group, but they are within the group of COPD, because they have chronic problem, it is obstructive and it is pulmonary, so they have COPD." (EX 6; pp. 26-27).

Dr. Zaldivar testified "I am absolutely certain he has asthma." (EX 7; p. 44). He explained that "nobody knows" what causes asthma, but it is not coal dust. (EX 7; p. 44). Dr. Zaldivar stated that bronchospasm is the same as asthma. Inflammation of the airway causes the bronchospasm. (EX 7; pp. 48-49). In discussing the cause of asthma, Dr. Zaldivar explained that it "simply happens in individuals who are susceptible to developing bronchospasm." (EX 7; p. 47). He further distinguished that asthma is reversible, but it is also permanent. (EX 7; p. 57). He did not find that Mr. Wriston is disabled, from a breathing standpoint. (EX 7; p. 62). Dr. Zaldivar also stated that Mr. Wriston has chronic bronchitis. He defined chronic bronchitis as "chronic productive cough for three months out of a year for two consecutive years." Dr. Zaldivar explained that chronic bronchitis is part of asthma. (EX 7; p. 67). Dr. Zaldivar did not find that Mr. Wriston has industrial bronchitis. He reasoned that industrial bronchitis is temporary while the individual is working in that environment. (EX 7; p. 68).

Dr. Zaldivar concluded that the Mr. Wriston's chronic obstructive pulmonary disease did not result from coal dust exposure, nor has it been aggravated by his coal dust exposure. He stated:

> The bronchodilator responsive COPD is by definition asthma, which is not, again by definition, coal workers' pneumoconiosis, nor is it by definition emphysema. It is outside both of those, but it partakes of the COPD diagnosis because it is chronic, it's obstructive and it's pulmonary.

(EX 6; p. 28). Dr. Zaldivar testified that coal mine dust cannot cause asthma. (EX 7; p. 36).

Dr. Zaldivar explained that X-rays of an individual with a bronchospasm problem often show hyperinflation. He illustrated that when an individual is suffering from severe attacks of bronchospasm, then the individual with asthma is going to trap a large amount of air that he cannot exhale, because the airways are obstructed and until the obstruction is relieved, the individual is going to trap air. An X-ray, taken under such circumstances, is going to be hyperinflated and it's going to look like emphysema. (EX 6; p. 30).

Dr. Zaldivar testified that simple coal workers' pneumoconiosis does not cause a restrictive impairment. He stated, simple pneumoconiosis can cause airway obstruction. If the obstruction is severe enough, it can cause hypoxemia. (EX 7; pp. 29-30, 35).

On January 26, 2004, Dr. Zaldivar was deposed again by Employer's Counsel. (EX 10). In anticipation of the deposition, Dr. Zaldivar reviewed the following additional materials: (1) a chest X-ray, dated January 7, 2004 and (2) a medical report by Dr. Robert Cohen, dated May 21, 2003. Dr. Zaldivar compared the January 7, 2004 X-ray with the X-ray taken during his examination of the Claimant. Dr. Zaldivar explained:

> [B]oth X-rays are identical. And that is how is that there is some pleural scars in the right upper zone, which I think should be looked at because they are isolated pleural changes related to pneumoconiosis. But they are different from the left side and now with the possibility [sic] of a tumor occurring in that area.

> Now, this was present before, however, so I don't think that it's anything other than old scars in there.
>
> There is no evidence of any pneumoconiosis. There is a possibility of hyperinflation with the diaphragms being slightly depressed or flat, although this impression was difficult to – I mean, this diagnosis is difficult to make on just one film. It would require two films to do this.
>
> But aside from the possibility of emphysema or hyperinflation from any causes and the pleural scars on the right upper lobe, there are no changes of any kind that – no pleural changes and certainly no pneumoconiosis.

(EX 10; pp. 4-5). Dr. Zaldivar testified that there are no changes indicating a coal mine dust induced lung disease. Dr. Zaldivar clarified that when he uses the term "coal workers' pneumoconiosis," he is referring to both legal and medical pneumoconiosis. (EX 10; p. 10).

In his December 28, 1993 report, Dr. Zaldivar diagnosed the Claimant with asthma. Dr. Cohen, in his report dated May 21, 2003, disagreed with this diagnosis. Dr. Zaldivar based his diagnosis of asthma on Claimant's clinical records. Mr. Wriston complained of a cough which becomes worse when near perfume and other agents. His coughing is relieved by inhalation of medications. Claimant told Dr. Zaldivar that this problem began around 1983, at which time he began using an inhaler. Dr. Zaldivar testified that this history demonstrates a manifestation of asthma, not coal workers' pneumoconiosis or emphysema. (EX 10; pp. 6-7). Dr. Zaldivar explained that asthma has bronchospasm with inflammation, due to inflammation of the airways. The inflammation is brought about by known specific agents and is relieved by the inhalation of bronchodilators. He stated that pneumoconiosis and emphysema have destruction of lung tissue, not inflammation. He explained that with destruction of the lung tissue there is no specific response to anything and there is no response to bronchodilators. (EX 10; p. 7).

Dr. Zaldivar elucidated that the ventilatory studies also show that asthma is present. Mr. Wriston had airway obstruction in every breathing test. Dr. Zaldivar stated:

> The diffusing capacity has been normal all along in spite of the presence of, more or less, airway obstruction. The difference between emphysema and coal workers' pneumoconiosis, the two have been together, as opposed to asthma is that with asthma, the lungs are intact. The capillary bed are intact.
>
> The airway obstruction is produced by inflammation, not by destruction of lung tissue. And, therefore, the diffusing capacity remains normal at most levels of airway obstruction. When airway obstruction becomes very severe, then there is problem with the testing itself because gases cannot penetrate to the areas of the lung where the capillary beds are, and then the diffusion may be low before bronchodilators but not after.
>
> But, the hallmark of asthma is a normal diffusing capacity in the presence of airway obstruction. And then the second factor is response to bronchodilators.
>
> So, Mr. Wriston has everything. He has the clinical history. He has the physiological findings of asthma. And so, his diagnosis is asthma.

(EX 10; pp. 8-9). Dr. Zaldivar explained that asthma is one of the causes of chronic obstructive pulmonary disease. Mr. Wriston was never treated vigorously for asthma. This results in permanent damage to the lungs caused by chronic inflammation to the lungs. (EX 10; p. 15).

Dr. Zaldivar stated that both asthma and coal mine dust exposure can cause airway obstruction. (EX 10; p. 19). Dr. Zaldivar found that Mr. Wriston's obstruction is caused by asthma. The moderate airway obstruction is not accompanied by any diffusion impairment. Thus, supporting a finding of asthma. Mr. Wriston's obstruction is not a result of destruction of the airway. "The fact that the diffusing capacity is normal in the presence of an airway obstruction even without any improvement after bronchodilators would allow anyone to suspect that asthma was really the problem." (EX 10; p. 21). In discussing different studies, Dr. Zaldivar stated "no studies have ever shown that asthma has anything to do with coal mining." (EX 10; p. 25).

Dr. Zaldivar discussed Mr. Wriston's ability to perform his last coal mine job. He stated that a cardiopulmonary stress test would have to be performed before he can determine whether Mr. Wriston is totally disabled. He explained that it is possible that Mr. Wriston may be disabled from performing his usual coal mine work because of airway obstruction. But, the question remains unanswerable there is no cardiopulmonary stress test. (EX 10; pp. 26-28).

Dr. Zaldivar analyzed the results of an April 2003 arterial blood gas test. Based on those results, Dr. Zaldivar concluded that Mr. Wriston could not do his usual coal mine work. He found, however, that his coal mine exposure did not play any role in his impairment. He stated, "Mr. Wriston has an airway obstruction which is due to asthma. Has nothing to do with coal workers pneumoconiosis and is not the result of coal workers pneumoconiosis." (EX 10; pp. 29-30).

Dr. Zaldivar stated that Mr. Wriston's history of exposure to coal dust is sufficient to have caused pneumoconiosis in a susceptible individual. In relation to Mr. Wriston, however, he concluded that coal dust played no role in the degree of Mr. Wriston's impairment. (EX 10; p. 34).

Dr. Cohen is a B-reader and is Board-certified in internal medicine with a subspecialty in pulmonary disease. (CX 4). His consultation report, based upon his review of the medical records of the claimant, on December 22, 1994, notes 33 years of coal mine employment and a 34-year smoking history. (DX 40). Dr. Cohen described the claimant's symptoms as wheezing, shortness of breath and cough productive of sputum.

Based on arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Cohen diagnosed pneumoconiosis. Dr. Cohen stated that Claimant has pulmonary function testing on at least four occasions which consistently shows moderate obstructive lung disease. Dr. Cohen found that these studies are of good quality. He also stated that the cardiopulmonary exercise tests showed a ventilatory limit to exercise. Dr. Cohen looked at chest X-rays interpreted as both positive and negative. He stated that even if the X-ray evidence were "judged as negative" it would not change his opinion. (DX 40).

He opined that the claimant's pulmonary condition was related to his coal dust exposure. While acknowledging that smoking can cause obstructive lung disease, Dr. Cohen concluded, "[i]t is my opinion that it is likely to a reasonable degree of medical certainty that Mr. Wriston's exposure to coal dust during the course of his coal mine employment contributed significantly to the development of his obstructive lung disease, ventilatory limit to exercise, blood gas and gas exchange abnormalities." (DX 40). Dr. Cohen asserted that Mr. Wriston's degree of obstruction and abnormalities would be disabling for the exertional requirements of his last mining job.

Dr. Cohen wrote an additional consultation report on May 21, 2003. (CX 1). Dr. Cohen based this report on the history, physical exam, chest X-ray and pulmonary function test performed at Cook County Hospital on April 29, 2003. Dr. Cohen stated that Mr. Wriston's work history reveals significant exposure to coal mine dust. He also reviewed his December 22, 1994 report. Dr. Cohen described the claimant's symptoms as progressive shortness of breath for more than 20 years and an occasional substernal burning sensation. Dr. Cohen noted a 34 pack year smoking history.

Based on arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Cohen diagnosed coal workers' pneumoconiosis. The pulmonary function test performed on April 29, 2003, showed severe obstructive defect, with no clear response to bronchodilators. Dr. Cohen further stated that if the X-ray evidence in total was interpreted to be negative, it would not change his diagnosis of pneumoconiosis.

Dr. Cohen disagreed with Dr. Tuteur's diagnosis of asthma. (CX 1). Dr. Cohen found chronic obstructive lung disease with a reversible component. Dr. Cohen explained "[a]t no time did his FEV_1 reverse to normal which would confirm a diagnosis of asthma." Dr. Cohen stated that Mr. Wriston consistently had moderate obstruction. He further explained that the symptoms of cough and wheezing are not, in and of themselves, diagnostic of bronchial asthma. Dr. Cohen determined that Mr. Wriston's FEV_1 never reached a level greater than moderate impairment. (CX 1). He elucidated "[c]oal miners, with obstructive lung disease due to coal dust, have also been demonstrated having bronchial hyper-responsiveness and reversibility."

He opined that the claimant's pulmonary condition was related to his coal dust exposure. Dr. Cohen stated "I believe that his chronic respiratory condition is substantially related to his more than 40 years of coal mine employment and his 34 pack years of tobacco smoke exposure." (CX 1).

Dr. Cohen concluded that Mr. Wriston's impairment "would certainly be disabling for his last coal mine job operating a ram car." (CX 1).

Dr. Tuteur is Board-certified in internal medicine and pulmonary medicine. His consultation report, dated December 28, 1994, based upon his review of the medical records of the claimant, notes 44 years of coal mine employment and a smoking history from the mid-1940's to 1980. (DX 41). Dr. Tuteur described the claimant's symptoms as intermittent breathlessness, cough and wheezing.

Based on arterial blood gases, a pulmonary function study, and chest X-rays, Dr. Tuteur diagnosed no pneumoconiosis. He found no convincing data for the existence of

pneumoconiosis. He stated that the medical evidence shows a moderate obstructive ventilatory defect, which improved significantly with a bronchodilator. He stated that the clinical features documented for Mr. Wriston, cough, wheezing and chest pain, are more consistent with chronic obstructive pulmonary disease than simple pneumoconiosis.

He opined that the claimant's pulmonary condition was not related to his coal dust exposure. Dr. Tuteur concluded "that the primary pulmonary process adversely affecting the health status of Mr. Wriston is that of tobacco-smoke-caused chronic obstructive pulmonary disease that developed superimposed on childhood pneumonias." (DX 41). Dr. Tuteur found that Mr. Wriston is totally disabled.

On January 29, 2002, Dr. Ranavaya performed another Department of Labor Exam. (DX 72). He diagnosed Mr. Wriston as having emphysema, chronic obstructive lung disease. Dr. Ranavaya stated that this was "most probably caused by 35 pack year history of cigarette smoking." He also diagnosed hypertension. Dr. Ranavaya did not find that claimant's illness is caused by coal dust exposure.

Dr. Ranavaya concluded that Mr. Wriston's impairment would prevent him from performing his last coal mine job.

Dr. Gregory Fino, who is Board-certified in internal medicine with a subspecialty in pulmonary diseases, and is a B-reader, reviewed the claimant's medical records on behalf of the employer and submitted his opinions in a report, dated May 21, 2003. (EX 5). Dr. Fino concluded that Mr. Wriston does not suffer from coal workers' pneumoconiosis. Dr. Fino determined that Mr. Wriston suffers from asthma, which is an impairment that "could be almost entirely eliminated." (EX 5).

In discussing his conclusion, Dr. Fino stated that the majority of chest X-ray readings are negative for pneumoconiosis. He further stated that the spirometric evaluations show marked variability with changing FEV_1 values over time and improvement with bronchodilators. Dr. Fino explained that such changes are not consistent with coal workers' pneumoconiosis. (EX 5). Dr. Fino stated that bronchodilators are medicines that work for reversible lung disease. He clarified:

> Breathing tubes have muscle in their walls. When the muscle contracts, the breathing tubs can become narrowed and constricted. Bronchodilators are used to open up the constricted breathing tubes. Coal mine dust inhalation causes an irreversible abnormality in the lungs which does not improve with bronchodilators. In other words, bronchodilators have no role or effect on the changes that may occur as a result of coal mine dust inhalation.

(EX 5). Dr. Fino also stated that Mr. Wriston's diffusing capacity values are normal. He explained that a "normal diffusing capacity rules out the presence of clinically significant pulmonary fibrosis." (EX 5).

Dr. Fino found that Mr. Wriston's pulmonary system is abnormal from a functional standpoint. Dr. Fino, however, also found that the Claimant retains the ability, from a respiratory standpoint, to perform his last coal mine job. (EX 5).

On January 28, 2004, Dr. Gregory Fino was deposed. (EX 8). Since his May 21, 2003 report, Dr. Fino has reviewed: (1) Dr. Cohen's report, dated April 29, 2003, (2) X-ray, dated October 30, 2002, (3) X-ray, dated December 8, 1993, and (4) X-ray, dated January 7, 2004. He also reviewed rereads of the January 7, 2004 X-ray, by Drs. Wheeler, Scott and Scatarige. (EX 8; pp. 5-6). Dr. Fino concluded that Mr. Wriston does not have medical or legal pneumoconiosis. To arrive at this conclusion, Dr. Fino analyzed the objective data. (EX 8; p. 7).

Dr. Fino explained that Mr. Wriston's 44 years of coal mine employment is "certainly enough coal mine dust exposure to cause a coal mine dust related pulmonary condition." He further stated that Mr. Wriston had a 35 pack-year smoking history, which is sufficient to cause a problem in a susceptible individual. (EX 8; p. 8). Dr. Fino did not find radiographic evidence of coal workers' pneumoconiosis. Dr. Fino acknowledged that Mr. Wriston has always had an obstructive type of abnormality present. The abnormality has varied over the years and has had improvement after the use of bronchodilators. Dr. Fino stated that such improvement is not consistent with a coal mine dust related pulmonary condition. Dr. Fino found no pulmonary fibrosis or pulmonary emphysema. (EX 8; p. 9).

Dr. Fino favors a diagnosis of asthma based on the improvement with bronchodilators and the variability in the FEV_1 values over time. (EX 8; p. 10). Dr. Fino discussed the effects of bronchoreversibility. Bronchoreversibility was seen in some of Mr. Wriston's test, but not seen in others. The fact that some of Mr. Wriston's results did not show bronchorevesiblity led Dr. Cohen to conclude that Mr. Wriston had a coal mine induced lung disease. Dr. Fino explained "[r]eversibility is characteristic of asthma, but it does not mean that all testings of an asthmatic have to show reversibility." (EX 8; p. 10). Dr. Fino stated that an irreversible obstruction may occur as a result of asthma. This type of obstruction is termed airway remodeling. Dr. Fino stated "10 percent of asthmatics have airway remodeling which can lead to irreversible obstruction." (EX 8; p. 11). Dr. Fino stated that there are "no studies to suggest that the airway obstruction that results from coal mine dust is bronchoreversible." (EX 8; p. 18). Dr. Fino stated that there is no medical literature suggesting that coal mine dust exposure cases asthma. (EX 8; p. 18).

Dr. Fino also determined that Mr. Wriston's diffusing capacity is normal. As a result, Dr. Fino concluded "[t]he normal diffusing capacity thus means that there is no actual lung tissue destruction, such as emphysema or fibrosis." Dr. Fino stated that the diffusing capacity is not very helpful in determining the etiology of the obstructive abnormality. He found that Mr. Wriston's obstruction has improved over time and then worsened, and has bronchoreversibility. Thus, leading to his conclusion that it is a non-coal mine dust related abnormality. (EX 8; pp. 11-12).

Dr. Fino next discussed the arterial blood gases. He found that a mild hypoxemia that was found was resolved when Dr. Zaldivar performed an arterial blood gas in 2002. The mild hypoxemia recurred, however, in the test performed by Dr. Cohen in 2003. Dr. Fino concluded that there is a variability in the hypoxemia that argues against a coal dust related condition. (EX 8; pp. 14-15). Dr. Fino concluded that there is a moderate respiratory impairment and a mild hypoxemia present, as of the date of Dr. Cohen's study. Dr. Fino testified that resting blood gas studies are not as useful a diagnostic tool for diagnosing coal workers' pneumoconiosis as an exercise blood gas study. (EX 8; p. 25).

Dr. Fino concluded that Mr. Wriston has a moderate obstructive abnormality. He also concluded that, based on Mr. Wriston's work description as a ram car operator that was required to shovel spills using a 50-pound shovel and Dr. Cohen's pulmonary function test results, he would be disabled. (EX 8; p. 20). Dr. Cohen described Mr. Wriston's job as a ram car operator, who also had to shovel spills four or five times a shift. Dr. Zaldivar stated Mr. Wriston's work history as a ram car operator, that consisted of operating a ram car. Dr. Fino stated that such a position requires no heavy labor. Thus, based on Dr. Zaldivar's job description, Dr. Fino found that Mr. Wriston would not be disabled. In regards to Dr. Cohen's pulmonary function test, Dr. Fino stated "I did not have the volume/time tracings, so I can't state with a reasonable certainty that it was a valid study because I just don't have the volume/time tracings."

Dr. Fino also testified that, based on the October 2002 pulmonary function test, Mr. Wriston would be able to do his usual coal mine work. Dr. Fino stated that the October 2002 pulmonary function test is a valid test. (EX 8; p. 22).

III. Claimant's Testimony

Mr. Wriston testified at the June 12, 2003 hearing. Claimant testified that he began working in the mines in February of 1948 and left the mines in 1992. Mr. Wriston spent a brief period of time in the Air Force from 1948 to 1952. (TR 24). Mr. Wriston was a ram car operator. Mr. Wriston described his duties:

> Load coal into the ram cars. The continuous minder loaded the coal into the ram cars, and we set there while they were loading them, setting in the seat, and eating that dust, you know. And when they load it, well we'd take it to the belt and dump it and then if the belt overflowed or something, we had to get out and shovel.

(TR 25). He stated that the car overflowed two or three times a shift. He estimated that a shovel full of coal weighted between 35 to 40 pounds. He also had to load timbers once or twice a shift. (TR 28). He testified that he lifted over a hundred pounds a day. (TR 29). Claimant did not wear a dust mask.

Mr. Wriston worked five or six days a week, at eight hours a day. He stated that he had breathing troubles and would get weak at work. Mr. Wriston retired at age 62, because his health was deteriorating. (TR 30). Claimant has not worked since he retired from Peabody Coal Company.

Claimant testified that he started smoking one pack a day at age 15. He stopped smoking at age 50, in 1980. (TR 32-33).

Mr. Wriston testified that at the date of the hearing he was six foot one inch and 238 pounds. He stated that this is similar to what he weighed when working in the mines. (TR 34). He stated that most of his time is spent at home, because of his health problems. He can no longer cut grass, hunt or coach baseball. He testified that he gets short of breath walking a city block or climbing a flight of stairs. (TR 35). Mr. Wriston sleeps with his bed on cinder blocks and uses two pillows. Claimant takes Atrovent, Albuterol and Serevent. (TR 37). Claimant was hospitalized for pneumonia in February 2003. (TR 41).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cr. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP [Williams]*, ___ F.3d ___, No. 01-4064 (6th Cir. July 31, 2003), *citing Greenwhich Collieries [Ondecko]*, 512 U.S. 267 at 281.

Since this is the claimant's third claim for benefits, and it was filed before January 19, 2001, under the old regulations, he must initially show that there has been a material change of conditions.[11]

To assess whether a material change in conditions is established, the Administrative Law Judge ("Administrative Law Judge") must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial of August 12, 1986, i.e., disability due to the disease. *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997); *Sharondale Corp. v. Ross*, 43 F.3d 993 (6th Cir. 1994); and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308, 20 B.L.R. 2-76 (3rd Cir. 1995). *See Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Unlike the Sixth Circuit in *Sharondale,* the Fourth Circuit does not require consideration of the evidence in the prior claim to determine whether it "differ[s] qualitatively" from the new evidence. *Lisa Lee Mines*, 86 F.3d at 1363 n. 11. The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995).

In *Caudill v. Arch of Kentucky, Inc.*, 22 B.R.B. 1-97, BRB No. 98-1502 (Sept. 29, 2000)(*en banc on recon.*), the Benefits Review Board held the "material change" standard of section 725.309 "requires an adverse finding on an element of entitlement because it is necessary

[11] Section 725.309(d) provides, in pertinent part:

> In the case of a claimant who files more than one claim for benefits under this part…[i]f the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the [Director] determines there has been a material change in conditions…
> (Emphasis added).

to establish a baseline from which to gauge whether a material change in conditions has occurred." Unless an element has previously been adjudicated against a claimant, "new evidence cannot establish that a miner's condition has changed with respect to that element." Thus, in a claim where the previous denial only adjudicated the matter of the existence of the disease, the issue of total disability "may not be considered in determining whether the newly submitted evidence is sufficient to establish a material change in conditions…"

The claimant's first application for benefits was denied because the evidence failed to show that: (1) the claimant had pneumoconiosis; (2) the pneumoconiosis arose, at least in part, out of coal mine employment; and (3) the claimant was totally disabled by pneumoconiosis. (DX 30). Under the *Sharondale* standard, the claimant must show the existence of one of these elements by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits.

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."[12] 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilisosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[13] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14

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[12] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1362; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 314-315. In *Henley v. Cowan and Co*., 21 B.L.R. 1-148 (May 11, 1999), the Board holds that aggravation of a pulmonary condition by dust exposure in coal mine employment must be "significant and permanent" in order to qualify as CWP, under the Act.

[13] The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that "coal dust specific diseases …attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See, e.g., Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[14] 20 C.F.R. § 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal co. v. Williams,* 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim field after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.; Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16

[14] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

B.L.R. 1-31 (1991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985).

A judge is not required to defer to the numerical superiority of X-ray evidence, although it is within his or her discretion to do so. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). This is particularly so where the majority of negative readings are by the most qualified physicians. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344(1985); *Melnick v. Consolidation Coal Co. & Director, OWCP,* 16 B.L.R. 1-31, 1-37 (1991).

The record contains multiple conflicting interpretations by various well-qualified B-readers and/or Board-certified radiologists. The most recent X-ray, dated January 7, 2004, has been read by two physicians as negative for pneumoconiosis. There are no positive readings of this X-ray. I therefore find this X-ray is negative for coal workers' pneumoconiosis.

Dr. Cohen made a positive reading of two X-rays, dated April 29, 2003 and October 30, 2002. The April 29, 2003 X-ray is missing, and has only been read by Dr. Cohen. There were four negative readings of the October 30, 2002 X-ray. Thus, I find the October 30, 2002 X-ray negative for coal workers' pneumoconiosis.

The record includes seven other X-rays. A positive reading of the August 9, 1994 X-ray was made by a dually qualified physician. It was also read by another dually qualified physician as completely negative. I find this X-ray in equipoise. The March 24, 1993 X-ray was read as positive by a dually qualified physician. There were also five negative readings of the March 24, 1993 X-ray by equally qualified readers. Thus, I find this X-ray as negative for pneumoconiosis. A dually qualified physician read the September 22, 1986 X-ray as positive for coal workers' pneumoconiosis. Two dually qualified physicians read the same X-ray as negative, I therefore conclude the X-ray is negative for pneumoconiosis.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[15] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

[15] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and expertise, as noted above, I rank Drs. Cohen, Fino, Tuteur and Zaldivar above Drs. Ramussen and Ranavaya.

Dr. Cohen concluded that the Claimant has coal workers' pneumoconiosis. He based this conclusion on the Claimant having an obstructive impairment due his exposure to coal mine dust and smoking. Dr. Cohen provides a detailed explanation of how obstructive impairment can be caused by coal mine dust exposure. He does not, however, provide a detailed explanation of how coal mine dust exposure caused Mr. Wriston's obstructive impairment.

Dr. Fino determined that Mr. Wriston likely suffers from asthma, not coal workers' pneumoconiosis. Dr. Fino provided a detailed explanation of how the objective evidence is consistent with asthma. He relied on a changing FEV_1 value over time and improvement with bronchodilators. Dr. Fino's deposition testimony further elaborates on his reasoning and conclusion. Dr. Fino explained that Mr. Wriston's bronchoreversibilty is a characteristic of asthma. Dr. Fino addressed Dr. Cohen's finding that some of Mr. Wriston's tests did not show bronchoreversiblity; and, explained that not every test of an asthmatic has to show bronchoreversibility for asthma to be present. Thus, although I find Dr. Fino and Dr. Cohen to have comparable qualifications, I find Dr. Fino's conclusion regarding Mr. Wriston's impairment more persuasive than Dr. Cohen's conclusions.

Dr. Tuteur found the Claimant has smoking induced chronic obstructive pulmonary disease. Dr. Tuteur explained that the objective evidence is typical of persons with partially reversible airways obstruction. He explained that Claimant's pulmonary problems do not persist over time, as would be found with coal workers' pneumoconiosis. Dr. Tuteur concedes that coal mine dust exposure can cause an obstructive impairment. He finds, however, that the reversibility seen in the case of Mr. Wriston supports the conclusion that his obstructive impairment is not due to coal mine dust exposure. I find Dr. Tuteur's explanation of how the objective evidence supports his conclusion more persuasive than Dr. Cohen's more generalized findings.

Dr. Zaldivar concluded that Mr. Wriston has asthma, not coal workers' pneumoconiosis. Dr. Zaldviar's report and deposition testimony explain his determination that Mr. Wriston's impairment is not due to coal dust exposure. Dr. Zaldivar found that Mr. Wriston has a reversible obstruction, which is evidence of asthma. He also explained that Mr. Wriston's problem with bronchospasm is not a problem that is caused by coal dust exposure. Dr. Zaldivar did find a chronic obstructive pulmonary disease. He explained, however, that asthma is a chronic obstructive pulmonary disease. I find that Dr. Zaldivar's detailed explanation of his conclusion is more persuasive than Dr. Cohen's opinion.

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documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984)…" In *Cornett v. Benham Coal, Inc.,* 227 F.3d 569, Case No. 99-3469, 22 B.L.R. 2-107 (6th Cir. Sept. 7, 2000), the court held if a physician bases a finding of CWP only upon the miner's history of coal dust exposure and a positive X-ray, then the opinion should not count as a reasoned medical opinion, under 20 C.F.R. § 718.202(a)(4).

Dr. Ramussen concluded that Mr. Wriston has coal workers' pneumoconiosis. Dr. Ramussen bases his conclusion on Claimant's long-term exposure to coal dust and X-ray changes which he finds are consistent with coal workers' pneumoconiosis. I find that Drs. Zaldivar and Fino provided a more detailed and persuasive explanation for Claimant's pulmonary problem than Dr. Ramussen.

Dr. Ranavaya, whose qualifications are not in evidence, found that Mr. Wriston has a chronic obstructive lung disease that is not related to his coal mine employment. Dr. Ranavaya does not provide a reason as to why it is not related to his coal dust exposure. Thus, I do not find Dr. Ranavaya's opinion persuasive regarding Claimant's pulmonary impairment.

I find the claimant has not met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. nom. Greenwich Collieries v. Director, OWCP,* 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993). Taken as a whole, the X-ray evidence and medical opinions, do not establish the presence of pneumoconiosis.

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had ten years or more of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of CWP has not been proven the issue is moot. Moreover, the presumption is rebutted by the medical opinion evidence discussed herein.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b). Section 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony. Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see*

also Shedlock v. Bethlehem Mines Corp., 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. *Coleman v. Ramey Coal Co.,* 18 B.L.R. 1-9 (1993).

The most recent pulmonary function studies produced differing results. The most recent, dated April 29, 2003, produced qualifying results. Dr. Cohen found a severe obstructive defect. Dr. Zaldivar's October 30, 2002 study produced non-qualifying results. I find these two studies so close in time as to be in equipoise.

A study performed in January 2002 produced non-qualifying results. A study performed on January 7, 1997 produced qualifying results. The physician who performed the 1997 study is not named. Furthermore, the qualifying study does not state whether the test was performed pre-bronchodilator or post-bronchodilator. (EX 4). The two pulmonary function studies performed in 1993 produced non-qualifying results. Tracings were not submitted with the September 26, 2000, July 14, 1998 and May 15, 1997 pulmonary function studies. Therefore, I give these studies little weight. Thus, the Claimant did not prove total disability based on the results of the pulmonary function studies.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii). More weight may be accorded to the results of a recent blood gas study over one which was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993).

Four arterial blood gas studies were performed. None of these studies produced qualifying results. Thus, the Claimant did not prove total disability based on the results of arterial blood gas studies.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medial judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, "…all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP,* 18 B.L.R.

1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

As stated above, the record includes the medical opinions of Drs. Cohen, Fino, Tuteur, Zaldivar, Ramussen and Ranavaya. Drs. Cohen, Tuteur, Ramussen and Ranavaya agree that Claimant is totally disabled and not able to perform his last coal mining job. Dr. Zaldivar is inconsistent in finding total disability. Because of his inconsistency, I give less weight to Dr. Zaldivar's opinion regarding total disability.

I find that the miner's last coal mining positions required heavy manual labor. Claimant testified that, as a ram car operator, he had to shovel coal two to three times a shift. He estimated that a shovel of coal weighed 35 to 40 pounds. Claimant also had to load timbers once or twice a shift. Dr. Fino concluded that based on Mr. Wriston's work description, he is totally disabled. However, Dr. Fino concluded that if Mr. Wriston merely operated a ram car and did not shovel coal, as described by Dr. Zaldivar, he would find that Mr. Wriston is not totally disabled. Thus, I classify Dr. Fino with the physicians concluding that Mr. Wriston is totally disabled.

As stated above, Claimant's last coal mining position required heavy manual labor. Because the claimant's symptoms render him unable to walk short distances or climb a flight of stairs, I find he is incapable of performing his prior coal mine employment.

The Fourth Circuit rule is that "nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis." *Jewell Smokeless Coal Corp. v. Street,* 42 F.3d 241 (4th Cir. 1994). In *Milburn Colliery Co. v. Director, OWCP, [Hicks]*, 21 B.L.R. 2-323, 138 f.3d 524, Case No. 96-2438 (4th Cir. Mar. 6, 1998) *citing Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994), the Court had "rejected the argument that '[a] miner need only establish that he has a total disability, which may be due to pneumoconiosis in combination with nonrespiratory and nonpulmonary impairments." Even if it is determined that claimant suffers from a totally disabling respiratory condition, he "will not be eligible for benefits if he would have been totally disabled to the same degree because of his other health problems." *Id.* at 534.

Based on the physician opinions, I find the claimant has met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Colleries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993). This represents a material change in conditions under 20 C.F.R. § 725.309.

E. Cause of total disability

The revised regulations, 20 C.F.R. § 718.20(c)(1), requires a claimant establish his pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability. The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) an d(ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes

only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 799946 (Dec. 20, 2000).

The Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" of the claimant's total disability. *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the claimant] suffers from a respirator or pulmonary impairment that is totally disabling and whether [the claimant's] pneumoconiosis contributes to this disability." *Street*, 42 F.3d 241 at 245.

According to the medical evidence, I find that Claimant has established that he suffers from a total pulmonary or respiratory disability. However, since the Claimant has not established (clinical or legal) pneumoconiosis by a preponderance of the evidence, he has also failed to establish total disability due to pneumoconiosis.

ATTORNEY FEES

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion, the claimant has established that a material change in condition has taken place since the previous denial, because he is now disabled. The claimant does not have pneumoconiosis, as defined by the Act and Regulations. The claimant is totally disabled. His total disability is not due to pneumoconiosis. He is therefore not entitled to benefits.

ORDER[16]

It is ordered that the claim of Mr. Wriston for benefits under the Black Lung Benefits Act is hereby DENIED.

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RICHARD A. MORGAN

Administrative Law Judge

[16] § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001). Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**[17]

[17] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is suffice to commence the 30-day period for requesting reconsideration or appealing the decision.

APPENDIX A

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO	Interpretation Or Impression
EX 9	1/7/04 1/13/04	Dr. Scott	B, BCR	2		Minimal infiltrate or fibrosis lateral right upper lung. Advice comparison to prior films and/or follow up. No evidence of silicosis/CWP. Hyperinflation lungs: deep breath emphysema.
EX 9	1/7/04 1/13/04	Dr. Wheeler	B, BCR	1		Chest Pa [2 pa]: subtle focal infiltrate or fibrosis lateral periphery RUL between anterior rigs 2-3 or pleural fibrosis near scapula. Hyperinflation lungs compatible with deep breath or emphysema with decreased upper lung markings favoring emphysema/check PFTS. Minimal degenerative arthritis mid T-spine seen on view with proper technique and hidden on view with moderate underexposure. At least minimal obesity. Small sidcoid atelectasis or scar right lateral CPA. Approximate CTR: 15-15.5/35 excluding cardiophrenic angle fat pads. No silicosis or CWP.
CX 2	4/29/03 5/19/03	Dr. Cohen	B	2	1/0	
CX 2	10/30/02 5/19/03	Dr. Cohen	B	2	1/0	
EX 2	10/30/02 11/04/02	Dr. Scott	B, BCR	2		Hyperinflation lungs: deep breath versus emphysema.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO	Interpretation Or Impression
EX 2	10/30/02 11/04/02	Dr. Wheeler	B, BCR	3-under exposure left scapulae on lung periphery		Normal except focal arteriosclerosis aortic arch and probable minimal obesity. Approximate CTR: 14-14.5/36 excluding epicardial fat. Light films accentuate and blur some fine lung detail but there is no silicosis or CWP.
EX 1	10/30/02 10/30/02	Dr. Zaldivar	B, BCI	2		No pleural abnormalities consistent with pneumoconiosis.
EX 3	1/29/02 12/20/02	Dr. Scott	B, BCR	2		Hyperinflation lungs compatible with emphysema or deep breath. Minimal bullous emphysema right apex. Minimal right apical pleural thickening.
EX 3	1/29/02 12/19/02	Dr. Wheeler	B, BCR	2		Minimal right apical pleural thickening and possible subtle left apical pleural thickening compatible with healed inflammatory disease. Hyperinflation lungs compatible with deep breath or emphysema/check PFTS. With possible linear scar or bleb wall right apex. Minimal degenerative arthritis and scoliosis T-spine curved right. CTR: 14/34 excluding cardiophrenic angle fat pad.
DX 72	1/29/02 1/29/02	Dr. Ranavaya	B	1	0/1	
DX 72	1/29/02 4/22/02	Dr. Binns	B, BCR	2		Quality Reading Only.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO	Interpretation Or Impression
DX 37	8/9/94 9/7/94	Dr. Deardorff	B, BCR	1	1/1	
DX 45	8/9/94 2/14/95	Dr. Wiot	B, BCR	2		Completely Negative.
DX 27	12/8/93 12/20/93	Dr. Zaldivar	B	2		Completely Negative
EX 2	12/8/93 11/15/02	Dr. Scott	B, BCR	2		Completely negative. Minimal apical pleural thickening.
EX 2	12/8/93 11/15/02	Dr. Wheeler	B, BCR	2		Normal except possible subtle apical pleural thickening and focal pleural fibrosis with tiny calcified granuloma lateral periphery RUL between anterior ribs 1-3 compatible with healed TB and possible minimal obesity. CTR: 13.5/35 excluding cardiophrenic angle fat pad
DX 39	12/8/93 8/9/94	Dr. Wiot	B, BCR	1		Completely Negative.
DX 39	12/8/93 8/15/94	Dr. Shipley	B, BCR	1		Possible Right Upper Lobe nodule – Rule out lung cancer. Recommend comparison to old or subsequent films.
DX 39	12/8/93 8/10/94	Dr. Spitz	B, BCR	1		Completely Negative.
DX 38	9/8/93 12/22/94	Dr. Wiot	B, BCR	2		Completely Negative.
DX 38	9/8/93 12/27/94	Dr. Shipley	B, BCR	2		Completely Negative.
DX 36	3/24/93 8/10/94	Dr. Binns	B, BCR	2		Plural thickening.
DX 36	3/24/93 8/10/94	Dr. Abramowitz	B, BCR	1		Hyperexpanded lungs. Scarring in the apcies. Plural thickening.
DX 36	3/24/93 8/8/94	Dr. Goginni	B, BCR	2		Hyperation
DX 15	3/24/93 5/7/93	Dr. Cole	B, BCR	1	0/1	

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO	Interpretation Or Impression
DX 14	3/24/93 4/28/93	Dr. Francke	B, BCR	1		Completely Negative
EX 3	3/24/93 12/20/02	Dr. Scott	B, BCR	2		Few small granulomata lateral right upper lung.
EX 3	3/24/93 12/19/02	Dr. Wheeler	B, BCR	3-under exposure spine and periphery lungs		Normal except subtle right lateral apical pleural thickening and possible left apical pleural thickening compatible with healed inflammatory disease, few tiny calcified granulomata or end on vessels and subtle degenerative arthritis T-spine. Approximate CTR: 12.5/35.5 Excluding cardiophrenic angle fat pad.
DX 16	3/24/93 3/24/93	Dr. Speiden	B, BCR	1	1/1	All Zones
EX 3	9/22/86 12/20/02	Dr. Scott	B, BCR	2		Few small granulomata lateral right upper lung.
EX 3	9/22/86 12/19/02	Dr. Wheeler	B, BCR	2		Normal except subtle right lateral apical pleural thickening compatible with healed inflammatory disease, few tiny calcified granulomata or end on vessel in lateral RUL and both lower lungs and minimal degenerative arthritis and subtle scoliosis T-spine curved right. Approximate CTR: 12.5/35.
DX 37	9/22/86 9/23/86	Dr. Bassali	B, BCR	1	1/2	All Zones.
EX 3	2/2/81 12/20/02	Dr. Scott	B, BCR	3-under exposure		Small calcified granuloma right mid-lung and possible few small granulomata periphery right upper lung.
EX 3	2/2/81 12/19/02	Dr. Wheeler	B, BCR	3-under exposure		Normal except possible tiny calcified granuloma

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO	Interpretation Or Impression
				pa/blurred fine detail on lateral		lateral right mid lung compatible with healed histoplasmosis. Approximate CTR: 12/34.5 excluding cardiophrenic angle fat pad.

* A-A-reader; B-B-Reader; BCR – Board Certified Radiologist; BCP – Board-certified pulmonologist; BCI – Board-certified internal medicine; BCI(P) – Board-certified internal medicine with pulmonary medicine sub-specialty. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram,* 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983) (Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc)(Unpublished)*. If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.